EXHIBIT NO. 17

01 09 15

GEICO INSURANCE
P.O.BOX 9515
FREDERICKSBURG VA 22403

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) / MEDICAID (Medicaid#) / TRICARE (ID#/DoD#) / CHAMPVA (Member ID#) / GROUP HEALTH PLAN (ID#) / FECA BLK LUNG (ID#) / OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
		046933249D101038	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
B[redacted] K[redacted] B[redacted]	[redacted] M[ ] F[X]	B[redacted] K[redacted] B[redacted]	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
146 Belmont St 2	Self[X] Spouse[ ] Child[ ] Other[ ]	146 Belmont St 2	
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE	
Malden / MA		Malden / MA	
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)	
02148 ( )		02148 ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
B[redacted] K[redacted] B[redacted]	a. EMPLOYMENT? (Current or Previous) YES[ ] NO[X]	a. INSURED'S DATE OF BIRTH / SEX	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	b. AUTO ACCIDENT? YES[X] NO[ ] PLACE (State) MA	[redacted] M[ ] F[X]	
948627907	c. OTHER ACCIDENT? YES[ ] NO[X]	b. OTHER CLAIM ID (Designated by NUCC)	
b. RESERVED FOR NUCC USE		c. INSURANCE PLAN NAME OR PROGRAM NAME	
c. RESERVED FOR NUCC USE		GEICO INSURANCE	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES[X] NO[ ] If yes, complete items 9, 9a, and 9d	
UNITED HEALTHCARE			

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 12 03 14 QUAL 431	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES[ ] NO[X] $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 9		22. RESUBMISSION CODE ORIGINAL REF. NO.
A 847 0 B 847 2 C 723 3 D 724 3 E 739 1 F 739 2 G 739 3 H 739 4 I J K L		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I ID QUAL	J RENDERING PROVIDER ID #
1 12 22 14 12 22 14	11		96941		A	70 00	1		NPI	1114937869
2 12 22 14 12 22 14	11		97014		A	60 00	1		NPI	1114937869
3 12 22 14 12 22 14	11		97010		A	35 00	1		NPI	1114937869
4 12 22 14 12 22 14	11		97012		A	75 00	1		NPI	1114937869
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER [redacted] SSN EIN [X]	26. PATIENT'S ACCOUNT NO. 5148-33850-1/1	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES[X] NO[ ]	28. TOTAL CHARGE $ 230 00	29. AMOUNT PAID $ 0 00	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Brian Farrell DC SOF SIGNED 01 02 15 DATE	32. SERVICE FACILITY LOCATION INFORMATION (Malden)Barron Chiropract 19 Pleasant Street Malden MA 02148-5106 a. 1013927730 b.		33. BILLING PROVIDER INFO & PH # (617) 2986325 Barron Chiropractic & Rehab P 1520 Blue Hill Avenue Mattapan MA 02126-1747 a. 1013927730 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

02 07 15

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

GEICO INSURANCE
P.O.BOX 9515
FREDERICKSBURG VA 22403

CARRIER

PICA

1 MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
					X		045933249O101038

2 PATIENT'S NAME (Last Name, First Name, Middle Initial)	3 PATIENT'S BIRTH DATE	SEX	4 INSURED'S NAME (Last Name, First Name, Middle Initial)
B[redacted] K[redacted] B[redacted]	[redacted]	M F X	B[redacted] K[redacted] B[redacted]

5 PATIENT'S ADDRESS (No., Street)	6 PATIENT RELATIONSHIP TO INSURED	7 INSURED'S ADDRESS (No., Street)
146 Belmont St 2	Self X Spouse Child Other	146 Belmont St 2

CITY	STATE	8 RESERVED FOR NUCC USE	CITY	STATE
Malden	MA		Malden	MA
ZIP CODE	TELEPHONE (Include Area Code)		ZIP CODE	TELEPHONE (Include Area Code)
02148	( )		02148	( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10 IS PATIENT'S CONDITION RELATED TO	11 INSURED'S POLICY GROUP OR FECA NUMBER
B[redacted] K[redacted] B[redacted]		
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH / SEX
949627907	YES X NO	[redacted] M F X
b RESERVED FOR NUCC USE	b AUTO ACCIDENT? PLACE (State)	b OTHER CLAIM ID (Designated by NUCC)
	X YES NO MA	
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT?	c INSURANCE PLAN NAME OR PROGRAM NAME
	YES X NO	GEICO INSURANCE
d INSURANCE PLAN NAME OR PROGRAM NAME	10d CLAIM CODES (Designated by NUCC)	d IS THERE ANOTHER HEALTH BENEFIT PLAN?
UNITED HEALTHCARE		X YES NO If yes, complete items 9, 9a, and 9d

PATIENT AND INSURED INFORMATION

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED Signature on File DATE

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SIGNED Signature on File

14 DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY	15 OTHER DATE QUAL MM DD YY	16 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
12 03 14 QUAL 431		
17 NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a / 17b NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19 ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20 OUTSIDE LAB? $ CHARGES
		YES X NO
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind 9		22 RESUBMISSION CODE ORIGINAL REF. NO
A. L847 0 B 847 2 C 723 3 D 724 3		
E L739 1 F 739 2 G 739 3 H 739 4		23 PRIOR AUTHORIZATION NUMBER
I. J. K. L.		

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B PLACE OF SERVICE	C EMG	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I. ID QUAL	J. RENDERING PROVIDER ID #
1 01 05 15 01 05 15	11		98941		A	70 00	1		NPI	1114937869
2 01 05 15 01 05 15	11		97012		A	75 00	1		NPI	1114937869
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25 FEDERAL TAX I.D. NUMBER	SSN EIN	26 PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29 AMOUNT PAID	30 Rsvd for NUCC Use
[redacted]	X	3148-94501-1/1	X YES NO	$ 146 00	$ 0 00	

31 SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32 SERVICE FACILITY LOCATION INFORMATION	33 BILLING PROVIDER INFO & PH #
Brian Farrell DC	(Malden)Barron Chiropract	(617)2886325
	13 Pleasant Street	Barron Chiropractic & Rehab P
	Malden MA 02148-5106	1320 Blue Hill Avenue
		Mattapan MA 02126-1747
SOF 02 02 15	a. 1013927730 b	a 1013927730 b
SIGNED DATE		

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